Delivering the Diabetes Prevention Program (DPP) to Medicaid Beneficiaries: Challenges and Solutions

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PURPOSE

To assess challenges and identify solutions to deliver the Diabetes Prevention Program to adults enrolled in Medicaid.

ABSTRACT

Purpose:

The purpose of this study was to assess challenges and identify solutions to deliver the DPP to adults enrolled in Medicaid.

Background:

In 2012, Montana (MT) Medicaid began reimbursing for the Diabetes Prevention Program (DPP). Since then, through collaboration with 14 DPP sites, we have increased participation of adults enrolled in Medicaid in the DPP.

Population:

Adults are eligible for MT Medicaid if they are blind, disabled, or pregnant, and meet low income financial requirements. Overweight adults with one or more risk factors for type 2 diabetes and cardiovascular disease are eligible for the MT DPP.

Methods:

In 2013, we conducted a qualitative assessment of DPP lifestyle coaches (N = 21) to identify challenges and solutions to recruit Medicaid beneficiaries and effectively deliver the DPP to this population.

Results:

Recruitment—Many coaches (71%) indicated it was very/somewhat difficult to recruit Medicaid beneficiaries. The most frequently reported barriers for participants were: commitment to follow through with enrollment and attending the initial sessions, and transportation.

Curriculum—Many coaches (71%) believed the DPP curriculum worked somewhat well for participants, while fewer believed it worked very well (19%) or not very well (10%). Most coaches (91%) reported challenges teaching components of the curriculum, particularly sessions addressing fat intake and self-monitoring (56%), problem solving (50%), portion sizes (47%), calorie balance (41%), and physical activity (35%). Coaches indicated that these sessions were too complex and provided too much information. Solutions identified were providing more 1-on-1 time with participants and simplifying session content.

Self-monitoring—Sixty-two percent and 33% of the coaches reported that participants found it challenging to document fat intake and physical activity, respectively. As a solution, 70% of coaches recommended using simpler self-monitoring tools.

Conclusion:

Our findings suggest that organizations should anticipate these challenges and address them to successfully deliver the DPP to low income and disabled populations.

INTRODUCTION

Type 2 diabetes is on the rise. The number of people diagnosed with diabetes increased from 1.5 million in 1958 to 18.8 million in 2010.[1] By the year 2050, one in three people will have diabetes.[2]

In 2011, 8% of Montana residents aged 18 years and older had diabetes, and an estimated 30% were at high-risk to develop diabetes.[3,4]

The prevalence of obesity and diabetes (41%, 16%) is significantly higher among adults aged 18 to 64 years enrolled in Montana Medicaid than among adults same age in the general Montana population (25%, 5%).[5,6]

METHODS

Intervention design:

The 10-month intensive lifestyle change intervention with 16 weekly core sessions followed by 6 monthly post core sessions using the National DPP curriculum. Sessions include healthy eating, physical activity, and problem solving topics. Participant goals are to lose 7% of their body weight through improved diet and increased physical activity.

Intervention sites:

The 14 sites that were assessed included outpatient hospital settings, hospital-YMCA partnerships, a local health department, and a rural health clinic.

As of 2014, the program has expanded to 18 sites and offers telehealth sites and satellite sites for additional access to the program (Figure 1).

Lifestyle coaches:

Trained health care professionals with experience and expertise in nutrition and physical activity. For example, a registered dietitian, registered nurse, or exercise physiologist.

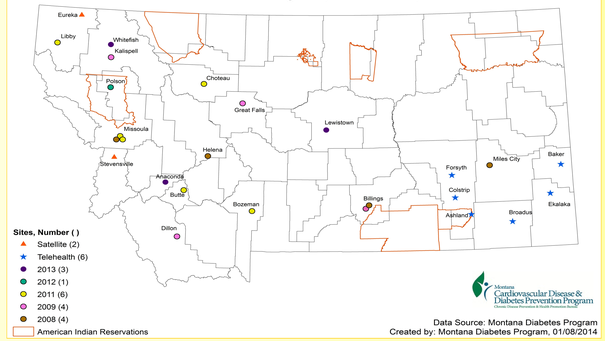
Population:

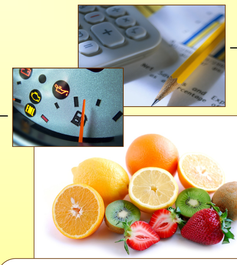
Targeted outreach and recruitment for adults Medicaid beneficiaries at high risk for diabetes began in November 2011. Promotion and marketing for referrals was conducted with primary care providers, Federally Qualified Health Centers, Centers for Independent Living, community programs, WIC, public assistance programs, and general media.

Reimbursement:

In 2012, Montana Medicaid included the DPP as a covered benefit. Medicaid reimburses $500 per Medicaid beneficiary for the 10-month program. This is billable by session attended at $21.88 per core session and $25.00 per post core session.

Figure 1. Intervention Sites, Montana Cardiovascular Disease & Diabetes Prevention Program, 2008-2014, Montana





Transportation
Engage case managers and family members to help with transportation to attend class. Use Medicaid transportation assistance services.

Self-monitoring fat grams
Allow alternative food journaling methods for participants with a developmental disability.

Accountability
If participants have difficulty following through with their intentions and committing to behavior changes, provide a supportive environment yet make them accountable. Promote coping skills.

CHALLENGES & SOLUTIONS

Challenges were noted in recruiting Medicaid beneficiaries, teaching some curriculum sessions, and self-monitoring fat and physical activity. Coaches found barriers to participant follow-through, commitment, and coping skills in adopting healthy habits.

Solutions were addressing barriers to participation such as providing transportation assistance and reminders to promote attendance, providing 1-on-1 time with participants and simplifying curriculum content for better comprehension, and simplifying tracking tools for improved self-monitoring.

"I often review material after class individually with participants who have learning challenges."

"The key is ongoing support from all angles and well beyond the coaches—case managers, physicians, therapists, family, friends."

"Never underestimate the insight and wisdom of the participants. They know themselves so well in terms of mental health—triggers, behaviors, ways to come back on track, and self-esteem. These strengths easily translate to other lifestyle behaviors like food and exercise."

"I always adjust my teaching based upon the entire group. I emphasize different things. I go with the flow to meet the needs of the group."

"I simplify the curriculum. I reiterate key points. I use demonstrations and visual aids. It also helps to provide 1-on-1 assistance."

METHODS continued

Assessment:

A qualitative assessment of lifestyle coaches was conducted in October 2013 with options to submit responses by email, fax, or paper. Reminders were sent to promote the response rate.

We aimed to receive feedback from the lifestyle coaches regarding their experience over the last two years recruiting, enrolling, and providing coaching to Medicaid beneficiaries. The goal of the survey was to identify successes, challenges, and lessons learned related to these areas.

RESULTS

The respondents were 21 lifestyle coaches from the 14 intervention sites in 2013.

Recruitment and Participation:

Many coaches (71%) indicated it was very or somewhat difficult to recruit Medicaid beneficiaries.

The most frequently reported barriers for participants were:

- Commitment to follow through with enrollment
- Attending the initial sessions
- Transportation

Curriculum:

Many coaches (71%) believed the DPP curriculum worked somewhat well for participants, while fewer believed it worked very well (19%) or not very well (10%).

Most coaches (91%) reported challenges teaching components of the curriculum, particularly sessions addressing

- Fat intake and self-monitoring (56%)
- Problem solving (50%)
- Portion sizes (47%)
- Calorie balance (41%)
- Physical activity (35%)

Coaches indicated that these sessions were too complex and provided too much information. Solutions identified were providing more 1-on-1 time with participants and simplifying session content.

Self-monitoring:

62% and 33% of the coaches reported that participants found it challenging to document fat intake and physical activity, respectively. As a solution, 70% of coaches recommended using simpler self-monitoring tools.

DISCUSSION

Programmatic Implications:

Lifestyle coaches and organizations delivering the DPP should assess participant barriers to enrollment, participation, and goal achievement in the program. Attention should be given to each participant's

- Health literacy and numeracy
- Learning style
- Disability
- Mental health
- Transportation needs
- Budget constraints

Public Health Implications:

The implementation of the DPP, an intensive evidence-based lifestyle change program, is a highly effective method of improving healthy behaviors and supporting weight loss with the ultimate goal of preventing or delaying type 2 diabetes and cardiovascular disease among adults at high-risk for these diseases.

Providing the DPP lifestyle intervention to Medicaid beneficiaries as a covered benefit has substantial health benefits for its population and likely also financial return on investment for Medicaid.

Clinical Implications:

Health care providers are recommended to

1. Assess patient risk for developing type 2 diabetes by an A1C, OGTT, or fasting blood glucose test.
2. Encourage patients to take the American Diabetes Association's Diabetes Risk Test, which provides a risk score, at http://www.diabetes.org/risktest.
3. Refer eligible patients to the DPP.
4. Learn more at www.mtprevention.org.

Conclusion:

Our findings suggest that organizations should anticipate the challenges described and address them to successfully deliver the DPP to low income and disabled populations.

References

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